

HOUSE BILL 7104

By Carringer

AN ACT to amend Tennessee Code Annotated, Title 8;
Title 56 and Title 71, relative to coverage of
behavioral health services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by
adding the following as a new section:

(a) As used in this section:

(1) "Contract provider" means a provider that is employed by or has
signed a provider agreement with an MCO to provide covered services;

(2) "Covered services" means the services and benefits available to a
TennCare enrollee;

(3) "Enrollee" means an individual eligible for and enrolled in the
TennCare program;.

(4) "In-network provider" means a provider who is enrolled with an
individual enrollee's MCO;

(5) "Managed care organization" or "MCO" means a health maintenance
organization, behavioral health organization, or managed health insurance issuer
that participates in the TennCare program;

(6) "Non-contract provider" means a provider that is not directly or
indirectly employed by or does not have a provider agreement with the MCO or
any of its subcontractors pursuant to the contract between the MCO and
TennCare;

(7) "Out-of-network provider" means a provider who is not enrolled with an individual enrollee's MCO; and

(8) "Quantitative treatment limitations" means limits on the scope or duration of a benefit that are expressed numerically, including limits on the number of days or visits.

(b) The bureau of TennCare shall:

(1) Require that each group health insurance contract, or group hospital or medical expense insurance policy, plan, or group policy delivered, issued for delivery, amended, or renewed in this state by an MCO on or after the effective date of this act shall not include quantitative treatment limitations for behavioral health services;

(2) Reimburse an in-network or contract provider for covered behavioral health services provided to an enrollee at a rate not less than one hundred eighty percent (180%) of the federal centers for medicare and medicaid services (CMS) medicare program's allowable charge for participating providers that is in effect at the time the service is provided; and

(3) Allow an enrollee to access an out-of-network or non-contract provider for covered behavioral health services and reimburse such provider at a rate not less than one hundred percent (100%) of the CMS medicare program's allowable charge for participating providers that is in effect at the time the service is provided. A provider reimbursed pursuant to this subdivision (b)(3) shall not bill an enrollee for an amount above the allowed amount.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it, and applies only to contracts or policies entered into, amended, or renewed on or after the effective date of this act.